Are community hospitals ready for the new world of revenue cycle management?

Written by José R. Sánchez, CEO, Norwegian American Hospital, Chicago; and Jesse Ford, CEO, Salud Revenue Partners | September 30, 2015

With the long-awaited rollout of the ICD-10 coding system at hand, surveys suggested that larger providers were nearly ready for the conversion, but smaller organizations were not, and likely faced claims and cash flow disruption.

The code set conversion, though a major story, is only the latest evidence that many community providers, including safety net hospitals, haven't adequately addressed fundamental challenges in the revenue cycle created by health payment reforms, vast changes in the insurance markets and the rise of healthcare consumerism.

The challenges abound:

- Affordable Care Act payment system reforms include value based purchasing, bundled payments, population health management and penalties for medical errors and readmissions.
- Reimbursement cuts include Medicare disproportionate share hospital payments, set to fall by $50 billion annually by 2019, and annual market basket reductions for most organizations. This is of particular importance to safety net hospitals, which already face operational challenges such as the medical, behavioral and social health status of their patients, aging plant infrastructure and labor issues. Further financial challenges for safety nets include the payer mix of the population served (Medicaid, uninsured) and less profitable service line offerings, such as neonatal intensive care, burn care and emergency mental health.
- Insurance market changes, including Medicaid expansion and new Medicaid managed-care entities; high-deductible health plans in both the individual and employer-sponsored markets; narrow provider networks, with huge cost differentials between in-network and out of network providers; increasing authorization requirements; and expanded review of medical records/clinical documentation.
- A new coding system, ICD-10-CM, which debuted Oct. 1. Some consider this to be the biggest challenge since Y2K. ICD-10-CM consists of more than 68,000 diagnosis codes, compared to approximately 13,000 diagnosis codes in ICD-9-CM. The implementation of ICD-10 will require retrained staff, education of physicians, additional coders and much more time per care episode.
- Internal limitations, including a lack of staff expertise on these issues, a lack of experienced coders, deficits in revenue cycle software and/or redundant programs and a lack of organizational focus on revenue cycle.

To be sure, revenue cycle management remains a core function in healthcare, but it only grows more difficult as traditional payment models shift to alternative arrangements and financial responsibility shifts to the patient.
One of the authors of this article is the CEO of Norwegian American Hospital, an inner-city safety net hospital in Chicago that has had success in optimizing the processes that increase cash collections, decrease accounts receivable, reduce bad debt write-offs and improve days’ cash on hand. The other author has led revenue cycle operations for inner-city healthcare organizations but now runs a revenue cycle management outsourcing company.

The core piece of revenue cycle can be done well in-house, but only if an organization has employees who know what they’re doing and good management that knows how to train the employees and manage processes in patient access services, billing and collection. Maintaining measurable and quantifiable goals, which are frequently communicated to the team, have further increased collections and reduced days in accounts receivable.

Areas that Norwegian American Hospital has outsourced include coding, collecting the self-pay portion of a patient’s bill, pursuing patient insurance coverage and completing government cost reporting. It requires monthly vendor performance reports, which are measured against the organization’s collection goals. Quarterly meetings are held to ensure performance meets the organization’s collection objectives and to account for any change in the local environment or corporate strategy.

However, more organizations are taking another look at outsourcing core revenue cycle functions, including billing, collection and follow-up, patient access, registration, scheduling and insurance verification. These providers have found that internal resources are lacking, employee talent too difficult to acquire or other priorities are taking precedence.

Whether revenue cycle is done in-house or through a vendor relationship, it is a largely untapped source of revenue for cash-strapped providers. Hospitals have cut staff and trimmed services in recent years to keep costs under control. Lately their last best hope seems to be using the Lean Six Sigma approach to eliminate waste from processes. And yet, for many hospitals, it’s easier today to find a dollar of revenue then it is to find another dollar of expense to cut.

In subsequent articles over the next few weeks, we will explore these revenue opportunities in greater depth, including:

- ICD-10 preparedness, by Dennis Price, CFO of PolyClinic, Seattle, and Jennifer Swindle, Salud Revenue Partners’ Vice President of Coding Solutions
- The challenge of patient self pay, by Michael Karf, MD, Executive Vice President for Health Affairs, University of Kentucky HealthCare, and Jesse Ford
- Revenue cycle readiness: When and why do you outsource? By Alan Channing, former CEO of Sinai Health System, and Jesse Ford

For now, some highlights.

**Patient self pay.** The statistics are stunning, as this issue leaps to the forefront of healthcare leaders’ concerns.

Employees in 2015 cover 43% of the total cost of care in employer-provided PPO insurance coverage, or $10,473 annually, according to the Milliman Medical Index. That represents an 8% increase to employees (overall) and a 5% increase to the employer over last year. The $10,473 amount is divided over two categories - out-of-pocket expenses incurred at the point-of-care ($4,065) and premium costs through payroll deductions ($6,408).

Nearly 37% of those under age 65 with private health insurance coverage were enrolled in a high-deductible plan, the National Center for Health Statistics reported in June. Nearly 20% of consumers have unpaid healthcare bills, the Customer Financial Protection Bureau reported last year. Fully a quarter or more of provider revenue now comes directly from patients, various analyses have found, up from just a few percentage points less than a decade ago.

And yet, in 2014, 39% of providers said that they did not know the amount of consumer responsibility during a patient visit, and 72% said that it took more than one month to collect from a consumer, the payment portal provider InstaMed said in a study, Trends in Healthcare Payments Fifth Annual Report: 2014. Some 58% providers surveyed said that their primary revenue cycle concern was related to consumer collections.

Patients are beginning to expect the same clear and concise information about — and control over — their medical services and financial options as they receive in banking and other consumer activity. Hospitals should be on the front lines, counseling patients at the point of service, assessing their financial capacity, and finding creative, engaging ways to help them pay.

We believe the first interaction with a patient with high out-of-pocket insurance coverage is an opportunity to share financial policies, gain patient commitment for their payment responsibilities, provide financial counseling and develop a payment plan, thus avoiding bad debt. Develop a brochure that details in plain language details about when to make payments and how, especially using an online patient portal address that gives patients the ability to check their balance, make payments and ask questions. Encourage revenue cycle staff to follow up with patients after they receive the packet, and ask patients if they have questions about the financial policies.

**ICD-10 conversion.** Although there is considerable debate about just how much disruption this new coding system will cause, two things seem clear:

- Coders will slow down because of the demand for greater specificity. This will create demand for additional coders to avoid under-coding and claims denials, and the prospect of a shortage. This may feed the movement toward outsourcing the coding function.
- A key to success remains educating physicians because their documentation directly supports accurate code assignment in ICD-10. Training resources for physician education and follow up may be another area where resource augmentation makes sense. Even after rollout, working with staff and referring physicians on greater
Outsourcing: Two recent reports show outsourcing of various aspects of revenue cycle management is on the rise – and why.

One study, by research firm peer60, is Healthcare Revenue Cycle Management: 2015. It examined how 122 hospitals and medical groups were contending with Affordable Care Act payment models. Many respondents said these new models have increased their interest in outsourcing some of their revenue cycle management. The top item providers will consider outsourcing is collections, which was chosen by nearly 46% of respondents. Twenty-five percent will consider outsourcing contract management and denial management, 22% will consider outsourcing claims and 16% will consider outsourcing eligibility and benefits.

A recent survey report from Black Book, a firm that produces comparative analyses of technology vendors, showed that 21% of hospital CFOs who chose to outsource their organization's revenue cycle management functions said that they would have been facing bankruptcy within the next four years if either state-of-the-art software or outsourced revenue cycle services were not implemented.

The same report, based on a poll of 2,250 CFOs, CIOs, business office managers, technology and financial services staffers, found that 83% of hospitals over 200 beds that moved to outsource all or most of their revenue cycle management operations have attributed revenue increases of 5.3% year-to-date in 2014 to a turnaround in post-outsourcing revenue cycle management efficiencies. About 78% of hospitals under 200 beds that were new to outsourcing revenue cycle also reported average revenue increases of 6.2% in 2014.

Even with all of the challenges of a changing payment environment, opportunities abound in optimizing revenue cycle management, as we will see in coming weeks.
ICD-10 still offers myriad challenges: More turn to outsourced services to generate bills, revenue

Written by Dennis Price, Chief Financial Officer, The Polyclinic, Seattle; and Jennifer Swindle, Vice President of Coding Solutions, Salud Revenue Partners | October 13, 2015

The relatively quiet first week of the transition to the ICD-10-CM coding system had some observers comparing it to Y2K, a supposed global computer crisis that was largely averted by some straightforward software programming.

Editor’s note: This is the second of four articles exploring revenue cycle challenges affecting community and safety net providers. Part 1 provided an overview of the issue. Coming soon are installments on patient self pay and revenue cycle readiness.

Don’t be fooled.

Behind the scenes we have already seen reports of commercial health plans rejecting claims for lack of specificity in clinical documentation. Organizations without up-to-date electronic medical records have experienced glitches in clinical documentation improvement (CDI) and computer-assisted coding (CAC) systems. Coders and physicians have spent hours on the telephone with insurer representatives who lack basic knowledge on the coding methodology.

The truth is we have yet to see the true impact of a shift from approximately 13,000 diagnosis codes in ICD-9-CM to more than 68,000 in version 10. Many coders are still working on bills for services delivered prior to the Oct. 1 debut of ICD-10. Even among hospitals and medical groups large enough to have done their due diligence to ensure that their internal systems and communication processes were in place in time, the impact of ICD-10-CM outside of their direct control could still have a significant impact to their medical and financial health.

A Sept. 29 survey by market research firm Black Book found the biggest coding concern of 70% of hospital CFOs is their payer’s lack of readiness due to denials and coding roadblocks to getting paid.

Black Book also found that 79% of hospitals over 200 beds were also confident in their coding resources yet only 16% had completed testing of ICD-10 between their facilities and all their respective payers.

Smaller community hospitals and safety net providers may not be ready for ICD-10 at all. They lack in-house expertise required to coordinate the shift across clinical, operational and financial operations.

One of the authors is CFO of The Polyclinic in Seattle, a large multispecialty physician clinic that has taken on full risk for claims and medical management of Medicare Advantage products with three different large commercial payers.
Through these arrangements, Polyclinic has worked with providers large and small, and while everyone has challenges, the brunt of ICD-10 will be taken by the smaller providers, especially physicians in solo practices and the smaller multi-specialty groups. If they are not on an electronic practice management system or full EMR, life just got a lot worse Oct. 1.

**Getting specific**
While ICD-10-CM still has many codes that are non-specific, the tremendous increase in number of codes and code expansions allows for much greater capture of specificity. For angioplasty alone, a cardiologist will have 845 different codes from which to choose. ICD-10-CM will better capture every patient's condition and allow for better measurement of outcomes and analysis of data. The Centers for Medicare and Medicaid Services publishes many local and national coverage determinations, which offer specific payment guidelines often based around diagnostic coding. Other payers also have payment policies that are impacted by diagnosis codes. With every diagnosis code changing, all of these policies will have to be revised and updated. This in turn opens up a prime opportunity for payers to become more stringent in their payment policies.

Clinical documentation improvement initiatives will need to play a much larger role in making certain the specificity needed to most accurately capture the condition and acuity of the patient is present in the documentation. Small changes can have a big impact on the accuracy of the code selected and paint a much clearer picture of the patient to the payer.

For example, there is a vague code in ICD-9-CM for limb pain; if the patient comes in with arm or leg pain in soft tissue that is not specific to a joint, the code is the same. In ICD-10-CM there are multiple codes that identify which limb and which part of the limb, so this one code translates to 31 different options. Using an unspecified code could potentially result in a denial for services if the location of the pain is not appropriately mapped to the location of the treatment.

**The big slowdown**
The complex nature of ICD-10 will undoubtedly slow coders down, exacerbating pre-existing conditions. The need for additional coders comes during a longstanding national and coder shortage.

ICD-10 is also going to slow physicians down, reducing the amount of time they can spend on direct patient care. That is just going to be a challenge for a period of time while physicians learn a whole new nomenclature.

Thus we will see slowdowns in patient care and coding on the provider side and claims processing on the payer side. This is why days' cash on hand is a key metric in revenue cycle management. Providers need enough cash to survive an inevitable cash flow squeeze as payers work through their own issues with ICD-10.

Healthcare organizations should use leading key performance indicators (KPIs) to compare performance before and after the migration to ICD-10. The following indicators will provide strong guidance on organizational performance with ICD-10:

- Initial claims denial rate, including reasons for rejection
- Average time to code a chart
- Gross accounts receivable (AR), days discharged not final coded
- Gross days in discharged not final billed (DNFB)
- Net AR days
- Cash collections as a percentage of net patient revenue

Another red flag of readiness problems is an EHR/EMR system that may still be mapping to ICD-9-CM codes. The trick will be to quickly identify whether this is happening and to be able to fix it promptly.

**Outsourced coding is paying off**
Black Book’s late September survey found that 93% of hospitals over 175 beds that had been outsourcing their CDI and CAC for more than nine months have testified to significant (over $1 million) gains in appropriate revenue and proper reimbursements following the implementation of outsourced services, but prior to ICD-10 transition. Additionally, 85% of CAC and CDI outsourcers confirm quality improvements and increases in the case mix index.

Providers that have not outsourced any functions to support ICD-10 may still benefit from support such as coder and CAC for more than nine months have testified to significant (over $1 million) gains in appropriate revenue and proper reimbursements following the implementation of outsourced services, but prior to ICD-10 transition.

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Meeting revenue cycle’s biggest challenge: The rise in patients’ share of the cost burden

Written by Michael Karpf, MD, Executive Vice President for Health Affairs, UK HealthCare, Lexington, Ky.; and Jesse Ford, CEO, Salud Revenue Partners | November 10, 2015

A stunningly fast shift from a time when direct patient payments were a miniscule source of income to today, when they make up more than a quarter of accounts receivable, has many community providers struggling to adjust.

Editor’s note: This is the third of four articles exploring revenue cycle challenges affecting community and safety net providers. Part 1 provided an overview of the issue. Part 2 explored the implications of ICD-10 readiness. The final installment will cover revenue cycle readiness and when it makes sense to outsource.

With the move to high deductible health plans set to accelerate further in 2016, now is the time to adjust policies and processes to help patients navigate this new payment paradigm and create a context for them to pay as much of their bills as possible.

When it comes to healthcare's self-pay problem, the numbers tell a big part of the story:

- Nearly a third of large employers now offer only high-deductible plans — up from 22% in 2014, according to the National Business Group on Health.
- Employees now cover 43% of the total cost of care in employer-provided PPO insurance coverage, or $10,473 annually, according to the Milliman Medical Index, an estimate of the total annual cost of healthcare for a typical family of four. Out-of-pocket expenses incurred at the point of care averaged $4,065, Milliman says.
- Bronze health plans, the most frequently purchased plan sold without federal subsidies under Obamacare in 2015, averaged a $5,181 deductible for individuals, reports HealthPocket, a firm that publishes health insurance market analyses.
- Nearly 20% of consumers have unpaid healthcare bills, the Consumer Financial Protection Bureau reported last year.

A recent report by InstaMed, a healthcare payment processing firm, shows how little prepared many in healthcare are for this new reality. The Trends in Healthcare Payments Fifth Annual Report found that in 2014, 39% of providers did not know the amount of consumer responsibility during the consumer visit, and 72% said that it took more than one month to collect from a consumer.

Not surprisingly, a majority of providers said that their primary revenue cycle concern was related to consumer collections.
Meanwhile, the Advisory Board reports that health systems and hospitals increased their annual revenue from point-of-service collections more than twice over in the last four fiscal years, in what experts said was largely a reaction to increasing numbers of patients receiving increased financial responsibility for their care.

“This move to collecting payment at or before the point-of-service reflects the industry’s experience that as more time passes after care is delivered, a patient's propensity to pay decreases substantially,” said Christopher Kerns, managing director of research and insights at the Advisory Board.

At UK HealthCare, the clinical health system and academic medical center at the University of Kentucky based in Lexington, the advent of Affordable Care Act health plans, with co-pays and deductibles in the range of $5,000 to $7,000, have been a substantial issue. Most people who signed up for those plans didn’t understand the out-of-pocket cost. Many of them get care before they’ve understood their policy and all of a sudden they have large payments due, which creates a problem for them and for the health system, which must walk a fine line between working to collect what's rightfully owed and helping patients access care without sliding into economic distress.

UK has a very structured approach on financial support and counseling. It identifies patients with large co-pays and tries to inform them on what that means at the front end. It has a policy that if a patient is below a certain level of ability to pay, the bill gets reduced accordingly. Staff works to structure approaches such as a monthly payment that is fair to everyone. There are, unfortunately, people of all levels of income who simply have no intention to pay, and UK does have a collection agency for those situations.

Surprisingly, UK HealthCare has not seen problems with its patient satisfaction scores as a result of these frustrations. There is anger at payers and employers, as well as disappointment when people begin to realize they have very large co-pays and deductibles. They've sort of come to understand that UK is sort of caught in the middle with them and tries to work with them to get through their payments in a reasonable manner.

UK is reasonably successful for an organization that’s large enough to have the resources and sophistication to be able to carry out these policies. But it is time and people expensive. That process of saving money is very inefficient, and most community hospitals don’t have those resources. It is why many of these processes are often outsourced to third-party vendors.

When it comes to patient financial issues, point of service best practices are evolving rapidly. There is growing evidence that a point of service focus can reduce the time and cost of collecting patient-owned bills and increase total self-pay collections. Some keys to the process include:

- You need to work through all of the opportunities to financially evaluate all patients, hopefully in a pre-access workup.
- You need to check for Medicaid eligibility, maybe as a secondary plan. If someone has a high out-of-pocket maximum, they may qualify as medically indigent. This could include children's, federal or state assistance.
- Efforts should be made to identify deductibles or co-pay amounts, inform the patient, and collect these amounts prior to discharge or release from service.
- If possible, invest in revenue cycle software with components that quickly assess insurance eligibility and benefits such as remaining deductible and out-of-pocket spend, and payment estimators that calculate the patient’s total bill.

Also, providers need to quickly establish whether a patient is in network or out of network, as today many insurance carriers might not pay any of the costs for an out of network provider.

Whether or not you are a community provider and have or have not implemented some of these best practices, you are probably still struggling to collect a significant portion of self-pay dollars. Patients of all stripes don’t follow through on payment plans or simply refuse to pay all or a portion of their co-pays. Estimates of patient responsibilities are not always precise.

If a balance remains, providers can choose traditional outsourced collection agencies – risking negative publicity for heavy-handed tactics – or adopt one of a plethora of new products that have come to market in recent years to aid in the process of recovering a significant portion of out-of-pocket costs. These patient-friendly applications range from interest-free payment plans to the use of social psychology to motivate payment on small balance receivables by a date certain.

Many new solutions are needed as healthcare grapples with the self-pay challenge, fast becoming one of the biggest financial issues faced by patients and providers today. It is only by working together that they may solve it.

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The revenue cycle outsourcing decision: finding a responsible partner that improves your finances without burning bridges

Written by Alan H. Channing, Principal, Channing Consulting Group, former President and CEO, Sinai Health System, Chicago; and Jesse Ford, CEO, Salud Revenue Partners | November 16, 2015

As we’ve discussed in the previous three parts of this series, healthcare providers face challenges on all fronts. They are having to improve care quality and patient satisfaction, lower readmissions and achieve Meaningful Use of electronic health records to meet the requirements of health reform.

Editor’s note: This is the fourth and final article of a series exploring revenue cycle challenges affecting community and safety net providers. Part 1 provided an overview of the issue. Part 2 explored the implications of ICD-10 readiness. Part 3 examined strategies for solving the patient self-pay challenge.

They also must manage costs, often through painful cutbacks on labor. Amid this frenetic activity, many providers – particularly smaller community hospitals and urban safety net systems – are missing an opportunity to improve financial results by tackling revenue complexity head-on.

Community and safety net hospitals often don’t have the depth and breadth of knowledge, people and technology to keep up with and transform their revenue cycle practices. Some really struggle with making the revenue cycle operation patient-friendly; patient satisfaction scores can plummet if the registration, billing and collections processes are inefficient or harsh.

As a result, many provider organizations are turning to outsourcing, seeking a revenue cycle partner that understands more than just billing and collections. The revenue cycle management market is expected to grow at a compound annual growth rate of 7.2% from 2014 to 2019, and it is one of the functions healthcare providers outsource the most, according to a January 2015 report from research firm MicroMarket Monitor.

Eighty-three percent of hospitals now outsource some accounts receivable and collections, according to a recent survey by Black Book, a firm that produces comparative analyses of technology vendors. More than two thirds (68%) of physician groups with more than 10 practitioners now outsource some combination of collections and claims management.

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This strategy is paying off: Eighty-three percent of hospitals over 200 beds that moved to outsource all or most of their revenue cycle operations attributed revenue increases of 5.3% in 2014 to a turnaround in post-outsourcing management efficiencies, Black Book found. Meanwhile, 78% of hospitals under 200 beds that were new to outsourcing revenue cycle operations reported average revenue increases of 6.2% in 2014.

When making the outsourcing decision, perhaps the most important question is, “Are you leaving money on the table?”
To start, validate that the chargemaster is up to date and charges are being captured. Then look at indicators of cash collections, such as HFMA’s MAP keys. Several of these statistics will provide insight into forgone revenue:

- Cash collections as a percent of adjusted net patient service revenue: a trending indicator of revenue cycle to convert net patient service revenue to cash.
- Denials as a percent of net revenue: a trending indicator of final disposition of lost reimbursement, where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount.
- Bad debt as a percent of net revenue: a trending indicator of the effectiveness of self-pay collection efforts and financial counseling.

A corollary to lost revenue is current need for cash. A huge issue for safety net hospitals today is days' cash on hand; these essential institutions are so fragile because days’ cash on hand are measured in single digits, compared with a moderately successful community hospital, which might have 120 days’ cash on hand.

The next question to ask yourself is, “Where is the best return on investment for improving our bottom line?” It is hard to argue that it is ever a bad decision to focus on quality. Some organizations have invested heavily in Lean and/or Six Sigma to eliminate waste in processes. Some have curtailed spending and/or reduced costs at least each year as part of their budget cycle. In fact, we have seen organizations that have cut so much, it seems easier to find a dollar of revenue cycle opportunity than it is to cut another dollar of expense. It is also less emotionally taxing on the decision makers as well as the rest of the organization.

Is your time best spent on improving customer service, increasing quality, reducing costs or collecting more for the services you provide? A focused review of your revenue cycle may reveal opportunities that span all these areas.

Finally, providers should honestly evaluate whether they have the time and resources to manage the complexity of the revenue cycle.

If the answer to the outsourcing question is yes, the problem of finding the right partner follows closely. We believe a good partner:

- Wants to seamlessly integrate into your operation, having an onsite presence to improve communication and enable easier decision-making
- Is committed to your vision, mission and values.
- Won’t treat you as a maintenance account, but is devoted to assuring you get paid for the care you provide.
- Deals with the community in a way that makes the client proud, particularly important when you’re talking about collections (think HCAHPS).
- Handles data through your systems, so when the engagement ends, the health system retains the data.

The value proposition for revenue cycle outsourcing includes service, management of the process, costs and collections.

You must be sure that the partner you select will represent you well with patients, physicians, administrators and the community. If not, you may find that your revenue falls as patients and/or their physicians choose competitors that treat them better.

If you believe that collections will not increase by changing vendors, you can focus on the cost and process equation. You can search for lower cost vendors, such as those that utilize technology to augment efficiency. Or, you can seek improvements in your own processes, using techniques such as Lean/Six Sigma. You will likely find that the revenue cycle offers seemingly endless, often wasteful, processes that beg for attention.

Perhaps the best return on investment will come from increases in cash collections. A good partner can boost collections by working aged accounts receivable, thus reducing days in AR. Other strong partners can identify revenue leakage, such as missing charges, and reduce denial and bad debt write-offs, which will improve your net revenue.

When considering alternatives, be comprehensive and rigorous in analyzing your model. What revenue improvement do you expect to realize in the first year? Will this grow in future years? Do you expect the vendor to bring addition resources, such as personnel or technology? We recommend that you carefully review the scope of the contract deliverables and consider building your own expense model to compare to the vendor's price. Your base model should incorporate additional investments you are contemplating – people and/or technology.

Having compiled your financial analyses, be careful to consider whether the vendor will be able to deliver the services and revenue improvement you expect for the price it offers. A contract with incentives that align with your organization’s goals will promote the partnership you expect with a new and valuable member of your team.

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